New Jersey Sheltering: The Local Perspective

By Natalie Pawlenko & Jennifer Barron
in conjunction with Mangeri Group, LLC

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TABLE OF CONTENTS

Executive Summary

This White Paper examines the little known role of local governmental public health in shelter planning, management and operations, for both general needs shelters (GNS) and medical needs shelters (MNS). During Superstorm Sandy, in many communities, local health departments were assumed and relied upon to be the entity responsible for staffing and operating both general population and medical needs shelters, despite lack of such a previously clearly delineated role among emergency response agencies. During this unique, wide-scale disaster, public health stepped up to protect and assist impacted New Jersey residents.

At the time of this research (July 2013), New Jersey's 565 municipalities were served by 95 local health departments (LHDs). This included single- and multiple-municipality health departments, as well as those that served our 21 counties. The sheltering survey which informed this White Paper included responses from 59 of the 95 health departments (62% response rate).

Over the past five years, 83% of respondents reported on being called upon to meet the sheltering needs of their communities. During this unprecedented storm, local health departments found themselves called upon to provide sheltering services for which many, if not all, had inadequate number of staff, inadequate health service supplies, and lack of appropriate training to assist medically needy and/or functional needs clients. LHDs were stretched beyond existing capacity as they endeavored to respond to escalating emergency needs as well as keep critical daily public health operations functioning.

Our primary survey research generated five key findings:

1. The percentage of local health departments participating in sheltering activities has reached an unprecedented level in the past five years;
2. Local health departments have been unexpectedly called upon/ expected to provide a broad array of sheltering services during emergencies, which required resources that many local health departments simply do not possess or have access to;
3. Staffing and operating a local Medical Needs Shelter requires more resources than most health departments can muster;
4. Acquiring and managing trained sheltering staff, equipment, and supplies are key challenges faced by LHDs; and
5. There is a need for policy and guidance around LHDs' role in sheltering.

Background

With the rising frequency and scale of weather events taking place in New Jersey, the need for coordinated and robust shelter operations, staffing, and supplies has become critical.

The role of governmental public health in emergency response, specifically mass care (sheltering), in New Jersey is little known and poorly understood. The purpose of this White Paper is to both gain a better understanding of this important function and to make recommendations which will strengthen the role of local health departments (LHDs) in the continuum of mass care operations and response.

New Jersey, fortunately, does not have a history of large scale, catastrophic disasters. Instead, New Jersey has experienced a series of localized events, which have had a significant impact on local populations and disaster operations.

Not until recently has there been a need for greater regional coordination due to an emergency event with significant impact on multiple jurisdictions. Specifically, since 2010, New Jersey has experienced a number of momentous weather events, including Hurricane Irene and Tropical Storm Lee (2011), Superstorm Sandy (2012), extensive flooding due to Nor'easters (2010, 2011) and severe winter storms (2010-2012). Hurricane Irene (2011) was the first hurricane to make landfall in the state since 1903, followed by Superstorm Sandy in late October 2012, the first storm of such magnitude to strike New Jersey.

Upon crashing onto the New Jersey shoreline, Sandy was technically an "extra-tropical cyclone" but nonetheless caused substantial damage that resulted in fatalities and mass evacuations of the general public, as well as that of skilled nursing facilities and hospitals. Initially forecast to hit south of Atlantic City, the storm ultimately caused more damage and destruction to the northern coastal communities of New Jersey, from Seaside through Perth Amboy and northward. Much of this coastal area has a population density exceeding 4,000 persons per square mile, thus making this particular section of the shore one of the most heavily populated coastal areas of the state.

As population density continues to increase in New Jersey, so does the need for coordinated shelter operations. Nationally, New Jersey ranks 1st in population density, thus the impact of population disruption and displacement can be significant.

Survey Methodology

In response to feedback from LHDs on Superstorm Sandy and the multiple issues raised concerning sheltering capacity and capability in both General Needs and Medical Needs shelters, a survey was conducted regarding LHD sheltering activities over the past five years and specifically during Superstorm Sandy.

A survey[1] consisting of quantitative as well as qualitative components was conducted in July of 2013 to identify and capture the experiences of those LHDs that have participated in shelter operations over the past five years (2008-2013). The sheltering survey was distributed to all 95 local health departments via an email from the NJ Department of Health's Office of Local Public Health. Respondents were asked to complete the survey within a ten-day window.

[1] Survey was developed by Office of Local Public Health and administered by an independent contractor.

Fifty-nine (62%) of LHDs completed the survey. Follow-up efforts were made to engage the remaining 36 LHDs, with limited success. Surveys continued to be accepted for a month after the deadline of July 31 2013 and data was incorporated into the results. Survey respondents covered the range in terms of size of health department, geographic distribution, and population size served. Skip logic was employed so that respondents were presented only with relevant questions, based on their responses to particular question sets.

In addition to the quantitative survey, twenty-one (21) qualitative interviews were conducted to provide additional depth and dimension to the quantitative survey results. (see Attachment 1: Interview Participants). The top nine LHDs most heavily impacted by Sandy were prioritized for interviews. Other considerations for interview selection included representation of various sizes of LHDs, geographical location of LHDs and general willingness of LHD staff to talk to the interviewer about their Sandy experiences. Topics for discussion included details on shelter activities; notification and communications strategies; roles and responsibilities in shelter operations; challenges and successes; and consequent suggestions for improving response. Interview discussions delved deeper into LHD experiences during sheltering and highlighted discovery of potential opportunities for future improvements in the disaster planning and emergency operations cycle.

Local Health Departments and Sheltering

> *Expectations and assumptions of public health involvement in local sheltering have grown significantly in recent years, raising questions regarding appropriate levels of staffing, resources and coordination with community shelter partners.*

Although the American Red Cross organization is perhaps most associated with emergency sheltering by the general public, this research revealed that **governmental public health is increasingly being called upon to respond to the emergency sheltering needs of their communities**. Consequently, this raises questions about the implications of this trend, as well as those concerning adequate resourcing for sheltering/mass care, appropriate recognition, and ongoing coordination with other key players in the emergency preparedness and response continuum.

To better understand the survey results in context, please note the following: General Needs Shelters (GNS) house the general public and are required to accommodate persons with access and functional needs, including chronic illnesses that can be managed in such a setting. Medical Needs Shelters (MNS) are smaller in nature and generally reserved for persons with medical needs (clinical care or equipment) that meet specified criteria whereby they cannot reasonably be served in a GNS.

The survey focused on two time periods regarding sheltering response at local health departments: (1) sheltering activities over the past five years and (2) sheltering activities specific to Superstorm Sandy.

Survey results regarding activities over the past five years revealed that:

- eighty-three percent (83%) of respondents reported that they were called upon to meet the sheltering needs of their communities;
- the majority (63%) initiated sheltering operations three times or fewer during this time period although a small number (19%) were engaged between 4 – 6 times; and

- Duration of shelter operations ranged from 8 hours to 30 days, with the average being approximately 7 days.

The following section examines local health department responses during Superstorm Sandy in the period October – November 2012.

Local Health Departments and Superstorm Sandy

> *Superstorm Sandy presented not only new challenges in sheltering but also prompted unanticipated levels of involvement and assistance from LHDs. Aside from shelter inspections, LHDs were relied upon heavily to staff and supervise both GNS and MNS in addition to providing hands-on care for both medically needy and access and functional needs shelter residents. Register Ready remains an underutilized resource.*

Modern emergency management planning was put to the test statewide as evacuees from the New Jersey coastal communities were re-located inward to evacuation shelters opened in other counties. Interstate mutual aid compacts were activated and federal assistance was also requested and arrived to provide necessary resources to keep the evacuated population safe and healthy.

Prior to Superstorm Sandy, many health departments had already initiated planning to assist with shelter operations because of the coordinated support they provided to their communities during Hurricane Irene in 2011 or earlier events. Others, who had not necessarily been part of shelter planning in their communities, were eventually called upon to assist with shelter activities during Superstorm Sandy.

According to American Red Cross's National Shelter System database, at their peak, there were approximately 120 local shelters reported to have opened to meet the sheltering needs of displaced New Jersey residents during Sandy[2]. Even with a 62% response rate, our survey indicated that at least 41 General Needs Shelters were managed and supervised by local health departments and their staff. Of these, 21 local health departments handled the management and supervision of Medical Needs Shelters. In addition to involvement with shelter operations during Superstorm Sandy, LHDs were involved in a number of other sheltering activities. Of the fifty-seven LHDs responding to the survey, many were active in GNS and MNS settings, undertaking the following:

- shelter food safety inspection (79%),
- medical assessment of shelter residents (68%),
- assisting those with functional needs/disabilities (78%),
- pet sheltering (53.5%), and
- coordinating transportation to/from shelters (56%).

Some additional details regarding the functioning of the Medical Needs Shelters operated by local health departments during Superstorm Sandy include the following:

[2] 78 Red Cross managed; 42 Independent of Red Cross assistance. Source: William Dura (Personal communication with Natalie Pawlenko, 3/12/2014)

- LHD top sheltering activities include staffing, set up, management/supervision, and tending to medical needs of shelter residents,
- 11 of 20 MNS reported sheltering under 25 individuals as their average daily census (55%);9 MNS reported sheltering between 25 – 100 individuals as their average daily census;
- The majority of 21 Medical Needs Shelters operated between 1 – 9 days, however, 9MNS (43%) were in operation for 10 or more days.

With regard to individuals with medical, access or functional needs, survey responses revealed that slightly less than half of the LHD respondents use Register Ready[3], the access and functional needs community registry. Of those not using this tool, about 18% indicated lack of use was due to the registry being the responsibility of another entity. Others pointed to use of a local registry in lieu of Register Ready or lack of access as reasons for not using this valuable resource.

The following sections examine successes and challenges in both General Needs and Medical Needs Sheltering for local health departments, as well as some examples of innovative and effective partnering.

Local Health Department Strengths in Shelter Operations

Communication, coordination and teamwork were the pillars supporting LHDs' ability to serve shelter residents. Ingenuity, creative approaches and non-traditional partnerships formulated during Superstorm Sandy were critical to meet unprecedented demands of sheltering.

Regarding the successes of LHD sheltering operations over the past 5 years, the survey data and subsequent interviews indicate that many LHDs were proud of the overall performance of their employees and demonstrated teamwork during the event response, as well as the subsequent planning efforts with their emergency management counterparts for future events. Many LHDs were involved and are still currently involved in post Superstorm Sandy after-action planning and dialogues to discuss lessons learned and improve future response efforts.

When asked to identify successes in the response to Superstorm Sandy and over the past five years, the top successes identified were as follows:

- intra-agency teamwork;
- interagency teamwork;
- coordination; and
- communications.

Cooperation and teamwork among LHD staff internally as well as between LHDs and their sheltering partners, including other LHDs and agencies, were identified as major factors in sheltering success. Thirty-seven percent of survey respondents (n=59) specifically identified cooperation from other

[3] "Register Ready – New Jersey's Special Needs Registry for Disasters" allows NJ residents with access and functional needs and their families, friends and associates an opportunity to provide information to emergency response agencies, so emergency responders can better plan to serve them in a disaster or other emergency. The information is confidential and is not available to the public. The information is held securely and only used for emergency response and planning.

agencies as one of their successes. Teamwork among their own LHD staff was reported by 34% of the respondents as another success of shelter operations. Interview discussions highlighted how the flexibility and adaptability of LHD staff helped to effectively meet the needs of the shelter residents during a stressful and vulnerable time. Coordination of activities among LHDs and other entities also ranked highly among factors contributing to successful sheltering.

Some examples of productive partnering and creative use of available resources include the following:

- Bernardsville High School set up hospital beds, not traditional cots, and the Visiting Nurse Association (VNA) staffed that "vulnerable adult" shelter.

- Community VNA in Somerset continued home services and provided services in shelters, with State of NJ helping by allowing fuel for clinicians serving the community.

  Bergen county reported successfully utilizing hotels to accommodate the needs of individuals with unique medical needs (immune issues, being contagious, post-operative patients, those who could not utilize traditional cots due to chronic illnesses) that could not be accommodated in the General Needs Shelter. This county ensured that medical and human needs were addressed by a case management team who followed individuals closely in order to ensure that unmet needs were addressed. This approach was highly effective in managing these unique medical needs while simultaneously being cost effective and avoiding overburdening staff.

Volunteer groups and accessible shelter sites also contributed to the success of LHDs in sheltering efforts. Survey respondents specifically noted help from the Medical Reserve Corp (MRC) as well as the ability to utilize schools for sheltering as beneficial. Another means by which LHDs assisted citizens without technically sheltering them included opening limited-hours warming centers or congregate care centers. These centers were able to meet the basic immediate needs of many displaced community residents simply by providing a place to charge cellular devices, get warm, and pick up bottles of water.

Local Health Department Challenges in Shelter Operations

The survey and the interviews conducted in support of this White Paper illustrated that many LHDs felt they were not adequately trained, were insufficiently staffed, and lacked appropriate supplies to provide for either staffing or operation of Medical Needs Shelters at the local level.

In addition to survey results reflecting challenges in sheltering, when interviewed about their experiences with Medical Needs Shelters and medical needs patients, there were a number of shared concerns expressed during the qualitative interviews. Some interviewees simply stated they were not of the understanding that the LHD is responsible for medical needs sheltering in their jurisdiction. Others indicated that medical needs sheltering cannot solely be a LHD function but rather, that hospitals must be involved to support medical needs operations in order for a local MNS to be viable.

A major challenge was the insufficient number of staff necessary to provide the level of care required by MNS residents. This troubling low staff-to-resident ratio was also experienced in many GNS. LHD staff indicated they lack the necessary clinical expertise, credentials and experience to serve the medical needs of many MNS residents as well as the chronic care needs of GNS residents.

In GNS, staff was frequently unable to meet the demands for support/care of access and functional need clients. Though not clinical care, the necessary assistance was hands-on, time-consuming, and required

some procedural training. (For example, help with Activities of Daily Living (ADLs) such as toileting, transferring, and feeding.)

An additional challenge rested in the fact that LHD staff were unfamiliar with home care issues and direct hands-on clinical care. Consequently, a need was voiced for better coordination between visiting nurses, home health aides, and sheltering partners in order to provide appropriate care to shelter residents. Many respondents identified strong concerns regarding providing health-related services in a shelter setting for the frail, the elderly and individuals who were normally homebound. Community residents with established home health care routines would be better served if those same services continued to be delivered in a shelter setting by aides of a local home health agency or long term care facility, especially if a caregiver is absent or unable to accompany a resident.

Moreover, the lack of statewide, universal triage guidelines resulted in wide variation among criteria used for MNS admittance, further complicating treatment, shelter consolidation or transfer. One specific dilemma experienced in both MNS and GNS shelter settings involves use of traditional cots; these cots do not meet the requirements of Functional Needs nor Medical Needs residents. There was also a significant unmet demand for bariatric wheelchairs for shelter residents.

Conclusion

Survey and interview results strongly demonstrate the need for action in several critical areas. Establishing/clarifying policies and procedures for General Needs Sheltering and especially, Medical Needs Sheltering, even beyond the need for universal triage guidelines should be a priority. There was a specific need expressed for State guidance with regard to managing a person who has health care needs beyond what can be delivered in a GNS, yet not of a level warranting hospital admission nor severe enough to meet Medically Needy Sheltering admittance criteria. During Superstorm Sandy multiple LHDs struggled to place and/or care for individuals falling into this "limbo" category.

Additionally, LHDs would appreciate clarification of State expectation with regard to the level of functional support that is expected in a GNS. Survey and interview comments indicate the need for hospitals to coordinate with sheltering partners, including LHDs, not only to assist in providing care through staff, but also to coordinate community hospital discharges and admissions with shelter personnel. These findings inform the recommendations that follow.

Recommendations

6 key recommendations address the priority issues raised by LHDs in the survey:

1. Develop universal triage guidelines for use at Medical Needs and General Needs Shelters throughout the state;

2. Enhance capability to serve Access and Functional Need clients in shelters through skills training;

3. Continue to support regional Mass Care planning (which will serve to address issues such as equipment/supplies inventory, shared service staffing agreements, & protocols for patient transfer);

4. Enhance sheltering capability through provision of trainings specifically geared to shelter settings, for any personnel from state and local health departments as well as community sheltering partners. (covering a breadth of distinct topics such as sheltering operations & administration, how to help residents with ADLs, how to provide non-clinical, supportive care to AFN individuals, provision of clinical care in shelter for public health nurses, & other licensed or certified care refresher training specific to a shelter setting);

5. State (DHS and DOH) develop guidance, policies and procedures reflecting State expectations for managing AFN individuals in GNS (ESF 6) and medically needy individuals in MNS (ESF 8); and

6. Collaborate with sheltering partners statewide to enhance and build resources supporting sheltering capability throughout New Jersey.

Discussion

The staff of the NJDOH Office of Local Public Health (OLPH) was responsible for staffing the Sheltering Desk at the DOH Health Command Center for the duration of Superstorm Sandy. Many of the issues identified in the survey were heard on a daily basis by Shelter Desk staff when fielding calls from local health departments, hospitals and others during the storm.

The survey validates what OLPH knew anecdotally, that, while mass care is considered to be a responsibility of the NJ Department of Human Services on the state level, this does not translate neatly down to the county or municipal level. More often than not, county and municipal public health departments are called upon to provide the sheltering leadership and staffing. What is also clear from discussions that have occurred since Sandy is that this is not widely known or understood by our emergency response partners (DHS, ARC, OEM, and others).

Further complicating the 'invisibility' of public health and its role in mass care is the capacity of public health staff to provide the health and medical care that is perceived to be its responsibility at shelters. Health department staff – with only a few exceptions (primarily those health departments that offer clinical services) – *do not* have the clinical training to provide more than just the very basics of care. During Superstorm Sandy, shelters operated by public health had guests presenting with a wide range of issues of varying degrees of acuity. Hospitals, hard pressed to decompress their facilities, were discharging patients whose needs could simply not be met by public health staff.

OLPH plans to use the results of this survey to educate both the emergency response partners on the current nature of mass care in New Jersey. The report will be equally helpful in assisting local health

departments in telling their story more effectively and ensuring that – if they are being called upon to serve – that they have the wherewithal to do so appropriately.

For further information, please contact:

Natalie Pawlenko, Public Health Infrastructure Laboratories Emergency Preparedness
609-633-6654

Jennifer Barron, Office of Local Public Health
609-341-4809

Progress on Recommendations

1. Develop universal triage guidelines for use at Medical Needs and General Needs Shelters throughout the state:

   1.1 "Modular Medical Expansion System" guidelines for Medical Needs Shelter (MNS) were developed Oct 2012. These documents include triage guidelines and an algorithm for the MNS.

   - All 21 county OEM agencies and all 21 county health departments received an electronic copy of these guidance documents.
   - Many of the 21 counties are using these documents in some manner when developing county MNS plans.
   - DOH regional staff was trained to the use of the Delta SOG and appendices.
   - What's needed is structured training across the state in collaboration with county OEM and their sheltering leads.

   1.2 Currently Local Health Department Nurses are developing "Medical Needs Sheltering Protocols" which can be added as appendices to this document once finalized.

2. Enhance capability to serve Access and Functional Need clients in shelters through skills training:

   2.1 Training specifically addressing Access and Functional Need clients in shelter was developed in cooperation with the New Jersey Medical Reserve Corp, New Jersey Department of Human Services/Division of Disability Services and the New Jersey Office of Emergency Management. This training was provided in the three regions of the state May 28th 2014 through June 26th 2014.

3. Continue to support regional Mass Care planning (which will serve to address issues such as equipment/supplies inventory, shared service staffing agreements, & protocols for patient transfer):

   3.1 Currently planning is taking place statewide through the Public Health Regional Workgroups and Regional Healthcare Coalitions.

   3.2 Additional attention is needed on the collaboration between hospitals and LHD/shelter partners in the provision of shelter medical staff in order to prevent the inappropriate movement of patients between hospitals and shelters.

4. Enhance sheltering capability through provision of planning, training and exercises specifically geared to shelter settings on a local level, for any personnel from state and local health departments as well as community sheltering partners. Training should include topics such as sheltering operations, administration, and assistance to evacuees with access and functional needs, provision of non-clinical supportive care for people with access and functional needs and provision of clinical care in the shelter by public health nurses, & other licensed or certified care refresher training specific to a shelter setting:

4.1 Shelter training for managers took place in March 2015 in a collaborative effort between DHS and NJDOH. Additional training is forthcoming.

5. State (DHS in conjunction with DOH) shall develop guidance, policies and procedures reflecting State expectations for (A) managing AFN individuals in a general needs shelter; (B) managing health/medical needs evacuees in GNS (ESF 6); and (C) managing medically needy individuals in MNS (ESF 8)

   5.1 Requires further development

6. Collaborate with sheltering partners statewide to enhance and build resources supporting sheltering capability and capacity throughout New Jersey. Encourage healthcare providers to become involved with sheltering planning, training, exercise and operations in their service areas. Explore MOUs with healthcare systems and provide medical support/staff when possible.

   6.1 The State Shelter Task Force, under the leadership of State Police, and having a membership comprised of DHS, ARC, DOH, Department of Agriculture, Department of Education and other key sheltering stakeholders, was created in 2014 and has led the efforts to identify sheltering capability and capacity throughout New Jersey.

Attachment 1: NJ Sheltering Survey Follow-up Interviews

Local Health Department

Bergen County Department of Health Services

Burlington County Health Department

Cape May County

Clark

Clifton and Little Falls

Cumberland County Health Department

Freehold Health Department

Hackensack

Hudson Regional Health Commission

Jefferson Township

Madison Health Department

Maplewood

Mercer Division of Public Health

Monmouth County Regional Health Commission

Salem County Health Department

Somerset County Department of Health

South Brunswick (Nursing)

South Brunswick (Admin)

South Orange

Union County Office of Health Management

Vineland Health Department